		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005462

Facility Name: Arthur Home THE

Address: 423 Eberhardt Drive (Number) Arthur (City) 61911 (Zip Code)

County: Moultrie

Telephone Number: (217)543-2103 **Fax #** (217)543-2278

IDPA ID Number: 370794402001

Date of Initial License for Current Owners: 1/1/1958

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: David Eversole **Telephone Number:** (217)543-2103

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2004 to 8/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David Eversole
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Chad Kunze, Principal
(Firm Name & Address) Larson, Allen, Weishair & Co., LLP, 12801 Flushing Meadows Drive, St. Louis, MO 63131
(Telephone) (314)336-3721 Fax # (314)336-3650

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	69	Skilled (SNF)	69	25,185	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,185	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	463	286	1,340	2,089	8
9	SNF/PED					9
10	ICF	10,558	12,020		22,578	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,021	12,306	1,340	24,667	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.94%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/1/1958

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 69 and days of care provided 1,340

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 8/31/2005 Fiscal Year: 8/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Arthur Home THE # 0005462 **Report Period Beginning:** 9/1/2004 **Ending:** 8/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	221,541	11,262	13,992	246,795		246,795		246,795			1
2	Food Purchase		134,868		134,868		134,868	(12,336)	122,532			2
3	Housekeeping	73,877	13,150	1,023	88,050		88,050		88,050			3
4	Laundry	65,130	9,307		74,437		74,437		74,437			4
5	Heat and Other Utilities			66,034	66,034		66,034		66,034			5
6	Maintenance	48,176		60,165	108,341		108,341		108,341			6
7	Other (specify):*											7
8	**TOTAL General Services**	408,724	168,587	141,214	718,525		718,525	(12,336)	706,189			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	1,058,998	58,438	3,905	1,121,341		1,121,341		1,121,341			10
10a	Therapy			77,306	77,306		77,306		77,306			10a
11	Activities	75,453	10,539	3,477	89,469		89,469	(14,234)	75,235			11
12	Social Services	48,520		914	49,434		49,434		49,434			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,182,971	68,977	89,602	1,341,550		1,341,550	(14,234)	1,327,316			16
	C. General Administration											
17	Administrative	74,482			74,482		74,482		74,482			17
18	Directors Fees											18
19	Professional Services			38,988	38,988		38,988		38,988			19
20	Dues, Fees, Subscriptions & Promotions			17,193	17,193		17,193	(1,670)	15,523			20
21	Clerical & General Office Expenses	112,049	16,849	23,687	152,585		152,585	(6,269)	146,316			21
22	Employee Benefits & Payroll Taxes			290,841	290,841		290,841		290,841			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,212	10,212		10,212		10,212			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,769	52,769		52,769		52,769			26
27	Other (specify):*											27
28	**TOTAL General Administration**	186,531	16,849	433,690	637,070		637,070	(7,939)	629,131			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,778,226	254,413	664,506	2,697,145		2,697,145	(34,509)	2,662,636			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Arthur Home THE #0005462 **Report Period Beginning:** 9/1/2004 **Ending:** 8/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			72,489	72,489		72,489		72,489			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			152	152		152	(152)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			72,641	72,641		72,641	(152)	72,489			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,835		34,835		34,835		34,835			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,761	37,761		37,761		37,761			42
43	Other (specify):*			42,007	42,007		42,007	(42,007)				43
44	**TOTAL Special Cost Centers**		34,835	79,768	114,603		114,603	(42,007)	72,596			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,778,226	289,248	816,915	2,884,389		2,884,389	(76,668)	2,807,721			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,310)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,818)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(331)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,095)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(41,141)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,795)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(14,873)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (14,873)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (76,668)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Arthur Home THE

ID# 0005462

Report Period Beginning: 9/1/2004

Ending: 8/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow X-Ray - Medicare	$ (6,911)	43	1
2	Disallow Lab - Medicare	(1,061)	43	2
3	Disallow House & Farm Property Expenses:			3
4	Depreciation	(2,540)	43	4
5	Real Estate Taxes	(4,096)	43	5
6	Utilities	(1,013)	43	6
7	Maintenance	(3,169)	43	7
8	Disallow Social Dues	(50)	20	8
9	Offset Interest Income Against Related Expense	(152)	32	9
10	Offset Vending Income Against Related Expense	(26)	2	10
11	Offset Activity Income Against Related Expense	(618)	11	11
12	Offset Transportation Income Against Expense	(13,616)	11	12
13	Offset Other Income Against Related Expense	(6,269)	21	13
14	Disallow Advertising	(1,620)	20	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(41,141)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arthur Home THE # 0005462 **Report Period Beginning:** 9/1/2004 **Ending:** 8/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,336)	0	0	0	0	0	0	0	0	0	0	(12,336)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,336)	0	0	0	0	0	0	0	0	0	0	(12,336)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(14,234)	0	0	0	0	0	0	0	0	0	0	(14,234)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(14,234)	0	0	0	0	0	0	0	0	0	0	(14,234)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,670)	0	0	0	0	0	0	0	0	0	0	(1,670)	20
21	Clerical & General Office Expenses	(6,269)	0	0	0	0	0	0	0	0	0	0	(6,269)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(7,939)	0	0	0	0	0	0	0	0	0	0	(7,939)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,509)	0	0	0	0	0	0	0	0	0	0	(34,509)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Arthur Home THE** **#** **0005462** **Report Period Beginning:** **9/1/2004** **Ending:** **8/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(152)	0	0	0	0	0	0	0	0	0	0	(152)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(152)	0	0	0	0	0	0	0	0	0	0	(152)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(27,134)	(14,873)	0	0	0	0	0	0	0	0	0	(42,007)	43
44	**TOTAL Special Cost Centers**	(27,134)	(14,873)	0	0	0	0	0	0	0	0	0	(42,007)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(61,795)	(14,873)	0	0	0	0	0	0	0	0	0	(76,668)	45

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Eberhardt Village	Arthur			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	43	Maintenance	$ 1,241	Eberhardt Village	100.00%	$	$ (1,241)	1
2	V	43	Advertising	4,083	Eberhardt Village	100.00%		(4,083)	2
3	V	43	Office Supplies	1,459	Eberhardt Village	100.00%		(1,459)	3
4	V	43	Training	1,200	Eberhardt Village	100.00%		(1,200)	4
5	V	43	Real Estate Taxes	3,045	Eberhardt Village	100.00%		(3,045)	5
6	V	43	Utilities	3,845	Eberhardt Village	100.00%		(3,845)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 14,873			$	$ * (14,873)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	N/A - no board members receive compensation								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	State Bank of Arthur		X	working capital	none	2/25/2003	150,000	31,153	2/25/2006	6.0000	152	6
7												7
8												8
9	TOTAL Facility Related						$ 150,000	$ 31,153			$ 152	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 150,000	$ 31,153			$ 152	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Arthur Home THE **#** 0005462 **Report Period Beginning:** 9/1/2004 **Ending:** 8/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arthur Home THE COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT David Eversole, Administrator

TELEPHONE (217)543-2103 FAX #: (217)543-2278

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes on		$	$
2.	non-care assets. All costs are		$	$
3.	adjusted out of the cost report.		$	$
4.			$	$
5.	03-03-25-425-007	415 S. Oak	$ 1,759.48	$ none
6.	03-03-25-406-009	PT S 1/2 SW 1/4 SE 1/4	$ 183.26	$ none
7.	03-03-25-406-003	Eberhardt Dr.	$ 133.80	$ none
8.	03-03-25-406-007	PT SW 1/4 SE 1/4	$ 6,089.52	$ none
9.			$	$
10.			$	$
		TOTALS	$ 8,166.06	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,236 B. General Construction Type: Exterior brick veneer Frame concrete, steel, wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

* Eberhardt Village - supportive living facility - construction of building was still in progress as of 8/31/2005, 8.8 acres, number of beds is yet to be determined

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	152,469	1959	$ 2,085	1
2					2
3	TOTALS	152,469		$ 2,085	3

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1959	1959	$ 124,966	$	33	$	$	$ 124,966	4
5	29		1975	1975	308,251	9,341	33	9,341		284,641	5
6											6
7											7
8											8
	Improvement Type**										
9	New Roof			1972	1,988		10			1,988	9
10	Fire Sprinkler System			1973	20,020		10			20,020	10
11	Fire Door			1973	2,400		10			2,400	11
12	Building Improvements			1973	2,646		10			2,646	12
13	Front Step and Ramp			1974	204		10			204	13
14	Heat Ducts			1974	942		10			942	14
15	Electric Breaker and Box			1974	30		10			30	15
16	Night Lights			1974	1,499		10			1,499	16
17	Heater for Ramp			1974	465		10			465	17
18	Concrete On Step & Ramp			1974	3,398		10			3,398	18
19	Pipe Insulation			1975	89		10			89	19
20	Field Tile			1975	54		10			54	20
21	Door Holder			1975	78		10			78	21
22	Water Heater			1975	1,461		10			1,461	22
23	Ward Door			1975	275		10			275	23
24	Concrete			1975	83		10			83	24
25	Plumbing			1975	57		10			57	25
26	Electrical			1976	677		10			677	26
27	Concrete			1976	2,884		10			2,884	27
28	Lights in Parking Lot			1976	327		10			327	28
29	Doors			1976	1,011		10			1,011	29
30	Insulation			1977	3,094		10			3,094	30
31	Roof Fan and Cooler			1978	2,252		10			2,252	31
32	Building Improvements			1978	1,316		10			1,316	32
33	Building Improvements			1978	451		10			451	33
34	Seamless Floors			1979	9,036		10			9,036	34
35	Building Improvements			1979	4,228		10			4,228	35
36	Remodeling Kitchen			1980	12,772		10			12,772	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1980	$ 552	$	10	$	$	$ 552	37
38	Roof	1981	23,816		10			23,816	38
39	Water Heater	1982	769		10			769	39
40	Parking Lot Addition	1982	4,577		10			4,577	40
41	Wood Folding Doors/Shade	1982	1,728		10			1,728	41
42	Remodeling Heating System	1982	22,500		10			22,500	42
43	Sewerage Improvements	1983	2,604		10			2,604	43
44	New Overhang	1983	4,120		10			4,120	44
45	Over Hang	1983	2,210		10			2,210	45
46	New Roof	1984	11,137		10			11,137	46
47	Firecode Paintroom	1985	1,214		10			1,214	47
48	New Front Doors	1985	2,333		10			2,333	48
49	New Bath & Beauty Shop	1986	13,969		10			13,969	49
50	Remodel Medicine Room	1986	1,886		10			1,886	50
51	Sprinkler System - Boiler Room	1987	1,971	79	25	79		1,445	51
52	Fire Doors	1987	1,097		10			1,097	52
53	Garage	1987	6,834	342	20	342		6,179	53
54	Boiler & Furnace Room	1987	96,626	3,865	25	3,865		70,537	54
55	Points on Construction Loan	1987	1,300	52	25	52		949	55
56	Floor Replacement	1987	1,016	51	20	51		906	56
57	New Water Heater	1987	3,238		15			3,238	57
58	Garage Wiring	1987	916	46	20	46		813	58
59	Floor Replacement	1988	900	45	20	45		765	59
60	Replacement Windows	1988	2,100	105	20	105		1,768	60
61	Doorways - Widening	1989	401	20	20	20		333	61
62	Sprinkler System - Kitchen	1989	2,523	101	25	101		1,674	62
63	Patio	1989	2,384	119	20	119		1,947	63
64	Kitchen Fire System	1989	1,005	40	25	40		637	64
65	New Flooring	1990	35,477	1,774	20	1,774		27,642	65
66	Shower Room Remodeling	1990	2,111	106	20	106		1,636	66
67	Basement Remodeling	1990	5,913	296	20	296		4,558	67
68	Patient Alarm System	1990	3,172		10			3,172	68
69	Curtain Tracks	1991	679		10			679	69
70	TOTAL (lines 4 thru 69)		$ 770,032	$ 16,382		$ 16,382	$	$ 706,734	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 770,032	$ 16,382		$ 16,382	$	$ 706,734	1
2	Door	1992	2,056		10			2,056	2
3	Ramp	1992	6,007	240	25	240		3,244	3
4	Gazebo	1992	10,636	532	20	532		7,135	4
5	Sprinkler System	1992	22,385	895	25	895		11,939	5
6	Building Improvements	1992	1,560	78	20	78		1,027	6
7	Electrical Heat Mats	1992	2,450	123	20	123		1,572	7
8	Roof	1992	1,569	78	20	78		994	8
9	Guttering	1993	1,362	68	20	68		863	9
10	Free Air Vents	1992	814	41	20	41		519	10
11	Remodel/DON Office	1993	3,970	199	20	199		2,448	11
12	Air Conditioner - Vent Work	1993	4,679		10			4,679	12
13	Fans & Lights	1993	802	40	20	40		475	13
14	Ramp, Rail, & Heater	1993	8,030	401	20	401		4,718	14
15	Roof Work	1994	3,150	158	20	158		1,811	15
16	Curtains	1994	382	19	20	19		218	16
17	Kitchen Windows	1994	300	15	20	15		169	17
18	Water Heater	1994	1,958		10			1,958	18
19	Bed Lights	1994	2,707	68	10	68		2,707	19
20	Windows	1995	39,488	1,974	20	1,974		20,073	20
21	Flooring	1995	454	23	20	23		240	21
22	Nurse Call System	1995	10,082	504	10	504		10,082	22
23	Doors	1995	2,733	137	20	137		1,389	23
24	Hot Water Pipes	1996	2,576	129	20	129		1,224	24
25	Shower Room Remodeling	1996	1,707	85	20	85		782	25
26	Lights	1996	1,366	68	20	68		609	26
27	Air Conditioner	1996	4,730	473	10	473		4,218	27
28	Lavatory	1996	1,778	89	20	89		785	28
29	Flooring	1997	15,671	784	20	784		6,726	29
30	Recover Walls	1997	27,143	2,714	10	2,714		22,393	30
31	Miscellaneous Improvements	1997	2,679	134	20	134		1,138	31
32	Insulation	1998	3,600	180	20	180		1,260	32
33	Basement Steel Posts	1998	4,639	232	20	232		1,720	33
34	TOTAL (lines 1 thru 33)		$ 963,495	$ 26,863		$ 26,863	$	$ 827,905	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 963,495	$ 26,863		$ 26,863	$	$ 827,905	1
2	Architectural Fees - Addition	1998	10,950	548	20	548		4,061	2
3	Air Conditioner	1997	6,752	675	10	675		5,289	3
4	Miscellaneous Bldg Improvements	1998	2,802	140	20	140		1,051	4
5	Parking Spaces	1998	1,596	64	25	64		426	5
6	Exhaust Fans	1999	221	11	20	11		73	6
7	Install Steel Plates Over Gutters	1999	484	24	20	24		143	7
8	Sink & Faucet	2000	1,401	93	15	93		529	8
9	Ducts	2000	404	20	20	20		113	9
10	Basement Door	2001	1,058	53	20	53		247	10
11	Back Doors	2001	2,687	134	20	134		571	11
12	Alarm System	2001	2,075	208	10	208		934	12
13	Ceiling Imp	2001	500	25	20	25		102	13
14	Grease Trap	2001	2,531	127	20	127		506	14
15	New Roof	2002	27,020	1,351	20	1,351		4,109	15
16	Miscellaneous Improvements	2002	1,489	74	20	74		261	16
17	Fire Sprinkler	2003	2,653	221	15	221		309	17
18	Cabinet	2004	748	87	10	87		125	18
19	Cabinet	2004	748	87	10	87		125	19
20	Draperies	2004	1,672	153	10	153		237	20
21	Draperies	2004	1,806	105	10	105		196	21
22	Sewer Line	2004	4,200	163	15	163		303	22
23	Shower Room Tile	2004	3,675	214	10	214		398	23
24	Draperies	2004	632	37	10	37		69	24
25	Counter Top	2004	980	57	10	57		106	25
26	Kitchen Tile Floor	2004	1,560	91	10	91		169	26
27	Cabinet	2004	755	44	10	44		82	27
28	Cabinet	2004	695	41	10	41		75	28
29	Exhaust Fan	2004	1,782	67	20	67		67	29
30	Back Step	2004	2,545	191	10	191		191	30
31	Basement Work	2005	10,465	262	20	262		262	31
32	Handrails	2005	7,045	196	15	196		196	32
33	Doors	2005	557	19	10	19		19	33
34	TOTAL (lines 1 thru 33)		$ 1,067,983	$ 32,445		$ 32,445	$	$ 849,249	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,067,983	$ 32,445		$ 32,445	$	$ 849,249	1
2	Carpet	2005	1,550	39	10	39		39	2
3	Ramps	2005	1,827	46	10	46		46	3
4	doors	2005	1,174	20	10	20		20	4
5	Roof	2005	8,000	133	10	133		133	5
6	Roof	2005	8,000	133	10	133		133	6
7	Roof	2005	16,103	268	10	268		268	7
8									8
9									9
10									10
11									11
12									12
13									13
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,104,637	$ 33,084		$ 33,084	$	$ 849,888	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 287,836	$ 28,628	$ 28,628	$	5-15	$ 143,449	71
72	Current Year Purchases	45,551	2,383	2,383		5-10	2,383	72
73	Fully Depreciated Assets	399,313				5-15	399,313	73
74								74
75	TOTALS	$ 732,700	$ 31,011	$ 31,011	$		$ 545,145	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1982 Ford Econoline Van	1986	$ 7,000	$	$	$	4	$ 7,000	76
77	Resident Care	1991 Ford Aerostar Van	1991	15,110				4	15,110	77
78	Resident Care	2001 Ford Supreme Bus	2001	45,103	8,394	8,394		4	45,103	78
79										79
80	TOTALS			$ 67,213	$ 8,394	$ 8,394	$		$ 67,213	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,906,635	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,489	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,489	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,462,246	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Donated Farm Land	$ 22,500	$	$	86
87	8.8 Acres Land - Lutheran Church	81,771			87
88	Funeral Home Land	143,696			88
89	Funeral Home Building	146,677			89
90	Rental House - 415 S. Oak	86,862	2,540	25,178	90
91	TOTALS	$ 481,506	$ 2,540	$ 25,178	91

G. Construction-in-Progress

	Description	Cost	
92	Eberhardt Village - various	$ 398,037	92
93			93
94			94
95		$ 398,037	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a(3)	hrs	$	840	$	50,400	$	840	$ 50,400	1
2	Licensed Speech and Language Development Therapist	10a(3)	hrs		229		8,205		229	8,205	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a(3)	hrs		821		49,581		821	49,581	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescrpts					34,835		34,835	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	1,890	$	108,186	$ 34,835	1,890	$ 143,021	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Arthur Home THE **#** 0005462 **Report Period Beginning:** 9/1/2004 **Ending:** 8/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 8/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 36,521	$ 44,911	1
2	Cash-Patient Deposits	2,980	2,980	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	365,271	365,271	3
4	Supply Inventory (priced at)	10,044	10,044	4
5	Short-Term Investments	148,665	148,665	5
6	Prepaid Insurance	7,507	7,507	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Contributions Receivable	323,445	323,445	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 894,433	$ 902,823	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	36,052	250,052	13
14	Buildings, at Historical Cost	883,248	1,029,925	14
15	Leasehold Improvements, at Historical Cost	308,252	308,252	15
16	Equipment, at Historical Cost	799,912	799,912	16
17	Accumulated Depreciation (book methods)	(1,487,424)	(1,487,424)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP		398,037	22
23	Other(specify): Due From Eberhardt Village	573,347		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,113,387	$ 1,298,754	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,007,820	$ 2,201,577	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 77,158	$ 77,158	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,980	2,980	28
29	Short-Term Notes Payable	31,153	31,153	29
30	Accrued Salaries Payable	37,833	37,833	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,791	18,791	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Other Accrued Expenses	7,144	7,144	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 175,059	$ 175,059	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 175,059	$ 175,059	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,832,761	$ 2,026,518	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,007,820	$ 2,201,577	48

***(See instructions.)**

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,122,956	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,122,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(96,438)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (96,438)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,026,518	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,698,260	1
2	Discounts and Allowances for all Levels	(195,348)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,502,912	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,611	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 94,611	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12,310	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	32,202	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	477	19
20	Radiology and X-Ray		20
21	Other Medical Services	72,185	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 117,174	23
	D. Non-Operating Revenue		
24	Contributions	31,313	24
25	Interest and Other Investment Income***	15,882	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 47,195	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Attached Schedule	26,059	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,059	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,787,951	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	718,525	31
32	Health Care	1,341,550	32
33	General Administration	637,070	33
	B. Capital Expense		
34	Ownership	72,641	34
	C. Ancillary Expense		
35	Special Cost Centers	76,842	35
36	Provider Participation Fee	37,761	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,884,389	40
41	**Income before Income Taxes (line 30 minus line 40)****	(96,438)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (96,438)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,622	5,622	$ 128,046	$ 22.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,128	4,128	81,599	19.77	3
4	Licensed Practical Nurses	14,204	14,204	244,779	17.23	4
5	CNAs & Orderlies	58,661	58,661	576,040	9.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,066	4,066	43,582	10.72	8
9	Activity Director	3,204	3,204	36,692	11.45	9
10	Activity Assistants	2,319	2,319	18,689	8.06	10
11	Social Service Workers	3,131	3,131	48,520	15.50	11
12	Dietician					12
13	Food Service Supervisor	2,334	2,334	28,476	12.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,098	22,908	193,065	8.43	15
16	Dishwashers					16
17	Maintenance Workers	3,732	3,732	48,176	12.91	17
18	Housekeepers	7,926	7,926	73,877	9.32	18
19	Laundry	7,008	7,008	65,130	9.29	19
20	Administrator	2,224	2,224	74,482	33.49	20
21	Assistant Administrator					21
22	Other Administrative	6,422	6,422	112,049	17.45	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	409	409	5,024	12.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,488	148,298	$ 1,778,226 *	$ 11.99	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	129	$ 5,657	1(3)	35
36	Medical Director	monthly	4,000	9(3)	36
37	Medical Records Consultant	24	2,100	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	650	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,738	11(3)	44
45	Social Service Consultant	48	1,738	12(3)	45
46	Other(specify) Dental	12	1,200	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	321	$ 17,083		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gary Coulter	Administrator	0	$ 28,886
David Eversole	Administrator	0	13,460
Jennifer Kresin	Administrator	0	32,136
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,482

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	legal	$ 2,558
Daniel Maher	legal	548
Samuels, Miller, Schroeder	legal	7,099
Altschuler, Melvoin & Glasser	accounting	20,552
Amer. Express Tax & Bus. Serv.	accounting	2,050
Schiff Hardin LLP	legal	5,131
Personnel Planner, Inc.	human resources	300
Expect the Best Productions	human resources	750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 38,988

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,622
Unemployment Compensation Insurance	15,374
FICA Taxes	132,217
Employee Health Insurance	111,127
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	501
TOTAL (agree to Schedule V, line 22, col.8)	$ 290,841

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,202
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous Subscriptions	187
Illinois Health Care Association	3,781
Other Taxes & Licenses	468
Advertising	1,620
Miscellaneous Dues	185
Life Services Network	750
Less: Public Relations Expense	(50)
Non-allowable advertising	(1,620)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,523

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,535
Seminar Expense	3,677
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,212

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Arthur Home THE # 0005462 Report Period Beginning: 9/1/2004 Ending: 8/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Arthur Home THE **#** 0005462 **Report Period Beginning:** 9/1/2004 **Ending:** 8/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Health Care Association - $3,781; Life Services Network - $750**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,624** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **37,761**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **12,310**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **13,616**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Larson, Allen, Weishair & Co., LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.